

the para aortic nodal areas to the level of the 12th thoracic vertebra. Some patients in whom positive aortic nodes have been so treated are apparently living free of tumor, but further studies of larger numbers are necessary to determine how many patients will benefit from these additional measures. At present, lymphangiography in cervical cancer is most useful when other diagnostic and therapeutic steps, such as surgical staging and expanded aortic treatment fields, are available. Because of the urgent need for accurate information about lymph node metastases, efforts to improve the usefulness of lymphangiography should continue.

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The Oxytocin Challenge Test

THE OXYTOCIN CHALLENGE TEST (OCT) is a method currently being used to evaluate uteroplacental respiratory function before labor. The test is done by recording fetal heart rate (FHR) and uterine contractions (UC) on a strip chart by means of a suitable external fetal monitor. The FHR response of late deceleration suggests uteroplacental respiratory insufficiency as shown by Hon and others during intrapartum fetal studies. Uterine contractions are known to interfere with uterine blood flow and are used in this test to provide an intermittent hypoxic stress to the fetus. If the FHR response to spontaneous or oxytocin-induced uterine contractions that are occurring at a frequency of three per 10 minutes shows no late deceleration (negative OCT), the fetus is believed to be in little or no danger of intrauterine demise for one week following the OCT. When persistent late deceleration of the FHR is present the patient is said to have a positive OCT and one can no longer be assured that the fetus will survive continued intrauterine existence. If fetal maturity is likely (lecithin-sphingomyelin ratio, $L/S > 2.0$) delivery would seem advisable. However, it should be emphasized that the positive OCT does not always signify imminent fetal danger and one should use other methods to assess fetal well-being (for example, a 24-hour urinary estriol test) when the

OCT is positive and fetal maturity is unlikely ($L/S < 2.0$).

The OCT gives rapid information about fetal well-being and has not been associated with an increased incidence of premature labor. It appears that the clinical value of the OCT is to allow one to avoid unnecessary premature delivery in patients at high risk for antepartum uteroplacental insufficiency.

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Cryosurgery

THE MANAGEMENT of benign diseases of the visible portion of the female genital tract has been significantly simplified following the introduction of cryosurgical therapy to the physician's armamentarium. Chronic cervicitis, that is, columnar tissue on the ectocervix, has been shown to respond favorably to outpatient cryotherapy with minimal complications. The success rate approaches 90 percent, and the technique is superior to hot cautery and avoids the hazards as well as expense of conization of the cervix. In fact, with the advent of cryosurgery, cervical conization is no longer warranted as treatment for "cervicitis."

When a physician desires to treat a patient with freezing for benign cervical disease, a Papanicolaou test must first be given and normal results obtained. Freezing is best done right after a menstrual period. During the treatment session, which is done without anesthesia or analgesia, it is most important that the iceball extend at least three to four millimeters onto healthy appearing tissue.

Cryosurgical therapy is also of benefit in the management of patients with resistant condyloma acuminata of the vulva, that is, non- or partially-responsive to podophyllin. When using the technique in a patient with vulvar condyloma acuminata, it is important to thoroughly freeze the base of the vulva but not an area greater than 2 or 3 cm in diameter in order to avoid excessive post-treatment complications.

The only significant sequela following cryosurgery has been a profuse watery discharge. Cervical stenosis and postoperative hemorrhage have not